MEDI-CAL UPDATE

Outpatient Services
Bulletin 347

Billing and Policy
Home Health Agencies and Home and Community-Based Services Bulletin 347

September 2003

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

HIPAA: Provider Manual Updates

The September 2003 Health Insurance Portability and Accountability Act (HIPAA) implementation resulted in the following changes in the Medi-Cal provider manuals. All changes are effective for dates of service on or after September 22, 2003.

Important: When you follow the remove and replace instructions in this bulletin and update your manual, please retain the pages you remove. Place them after the *Appendix* tab at the back of your manual. These page will help you bill for services that you rendered prior to September 22, 2003.

New HIPAA In Review

A handy *HIPAA In Review* guide has been included in this bulletin for you to insert in your provider manual at the end of the *UB-92 Completion: Outpatient Services* section. This guide summarizes important outpatient-related changes that resulted from the September 2003 initial phase of Medi-Cal HIPAA implementation.

Conversion of Place of Service to Facility Type Codes

Type of Bill Field (Box 4) and
Payer Field (Box 50)

4. TYPE OF BILL
734

Local Medi-Cal Place of Service codes are being replaced with national facility type codes, which are entered as the first two digits in the Type of Bill field (Box 4) in the upper right hand corner of the claim. Previously, Box 4 was optional but now is required. The third character in the Type of Bill field is a claim frequency code (a single number or letter).

50. Payer
O/P Medi-Cal ~~9~~

Local Medi-Cal Place of Service codes are no longer included in the Payer field (Box 50). The words "O/P Medi-Cal" are still required.

Manual Changes

- Facility type and claim frequency codes are explained in the *National Uniform Billing Committee (NUBC) UB-92 Billing Manual.* This information is included in the claim completion section.
- Medi-Cal manual references to Place of Service are changed to "facility type."

Please see **HIPAA**, *page 2*

HIPAA *(continued)*

- A *Code Correlation Guide* showing the relationship between Place of Service and facility type codes is added at the end of the *UB-92 Completion: Outpatient Services* section to help you understand how the Medi-Cal Place of Service codes have been converted to national facility type codes.

Conversion of Billing Limit Exception to Delay Reason Codes

Delay Reason Field (Box 31)

Condition Codes							31
24	25	26	27	28	29	30	**405**

Local Medi-Cal billing limit exception codes are being replaced with national delay reason codes. Delay reason codes are entered in Box 31, to the right of the Condition Codes boxes on the claim. Do not enter delay reason codes in the Condition Codes field (Boxes 24 – 30) where you previously entered billing limit exception codes.

- A *Code Correlation Guide* showing the relationship between billing limit exception and delay reason codes is added at the end of the *UB-92 Completion: Outpatient Services* section to help you understand how Medi-Cal billing limit exception codes have been converted to national delay reason codes.

"From-Through" Billing

Service Date Field (Box 45)

43. DESCRIPTION	44.	45. SERV. DATE
SERVICES FOR SEPTEMBER		**092203 ("From" date)**
9/21 9/24 9/27 9/29 9/30		**093003 ("Through" date)**

"From-through" services with a "from" date of service on or after September 22, 2003 are to be billed with national codes. "From-through" services with a "from" date prior to September 22, 2003 are billed with local Medi-Cal codes.

Guidelines

HIPAA changes for the September 2003 phase of HIPAA implementation established the following guidelines:

- Claims with dates of service on or after September 22, 2003 must be submitted with national condition, delay reason and patient status codes.
- Claims for services prior to September 22, 2003 must be billed with local Medi-Cal condition, billing limit exception and patient status codes.
- Claims for services rendered on dates of service that include both pre- and post-September 22, 2003 dates must be billed on separate claims (split billed) with national codes on one claim and local Medi-Cal codes on another.

"From-Through" Exemption

Claims for services that require "from-through" billing (identified in policy sections) do not require the split billing. They are billed as indicated in the italicized text under the preceding diagram.

Please see **HIPAA**, *page 3*

HIPAA *(continued)*

Manual Changes

- The *UB-92 Special Billing Instructions for Outpatient Services* section is updated to include the preceding "from-through" information.

Conversion of Condition Codes

Condition Codes Field (Boxes 24 – 30)

Medi-Cal condition code A3 is being changed to national condition code "AI," which is used to bill for services related to Family Planning (FP).

Emergency Services

Admit Type Field (Box 19)

ADMISSION			
17. DATE	18. HR	19. TYPE	20. SRCE
NA	**NA**	**1**	**NA**

Enter admit type code 1 when billing for outpatient emergency services. This is now a required field when billing for emergency services.

Manual Changes

- The *UB-92 Completion: Outpatient Services* section is updated to include instructions to complete the *Admit Type* field (Box 19) when emergency services are rendered.

Modifiers

HCPCS/Rates Field (Box 44)

44. HCPCS/RATES	45.	46.	47.	48.	49.
XXXXX2647					**6062**

Up to four modifiers may be entered on outpatient UB-92 claims. Modifiers one and two (-26 and -47 in the preceding example) must be billed immediately following the procedure code, with no spaces, in the HCPCS/Rates field (Box 44). The remaining two modifiers (-60 and -62 in the preceding example) are entered, with no spaces, in Box 49.

Manual Changes

- The *UB-92 Completion: Outpatient Services* section is updated to include instructions for billing with up to four modifiers.
- When billing for services rendered to recipients who are patients in subacute care facilities, you must enter facility type code "27" in the *Type of Bill* field (Box 4) and enter modifier -HA (pediatric) or -HB (adult) in the last-used modifier field. These modifiers must be submitted with every procedure on the claim.

Instructions for Manual Replacement Pages
Home Health Agencies and Home and Community-Based Services (HOM) Bulletin 347 — September 2003

Part 2

Remove and replace:	cif co 1/2 * hcpcs iii 1 thru 4 * home 7/8 * medi cr op 3/4 *, 7/8 *, 11/12 *, 23/24 *, 27/28 * medi cr op ex 3/4 *, 7/8 * medi non hcp 1/2 * oth hlth cpt 3 * preg post 1/2 * tar comp 9 thru 12 * tar dis cod 3/4 *
Remove: Insert:	ub comp op 1 thru 21 ub comp op 1 thru 30 *(new)*
Remove:	*Condition, Occurrence and Value Codes Quick Reference List*
Insert at end of *UB-92 Completion: Outpatient Services* section:	*HIPAA In Review (new)* *Code Correlation Guide (new)*
Remove: Insert:	ub spec op 1 thru 8 ub spec op 1 thru 9 * *(new)*
Remove and replace:	ub sub 1 thru 5 *
Remove: Insert:	ub tips op 1 thru 3 ub tips op 1 thru 4 * *(new)*

* Pages updated/corrected due to ongoing provider manual revisions.